DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155109			LDING	NSTRUCTION  00	CON	TE SURVEY  MPLETED  3/2011
	PROVIDER OR SUPPLIER			811 E 1	ADDRESS, CITY, STATE, ZIP COI 2TH ST WAKA, IN46544	DE	
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Complaint 00088 00089345, and 0 Complaint Numb Unsubstantiated Complaint Numb Substantiated, not the allegations ar Complaint Numb Substantiated, not the allegations ar Complaint Numb Substantiated, Ferelated to the allegation and F465.	one one of evidence.  one of evidence.  one of evidence.  one of evidence.  one of one evidence related to the evidence of evidence related to the evidence related to the evidence of evidence related to the evi	FO	0000	Disclaimer Statement: Submission of the plar correction is not an ad that a deficiency exists they were cited correct Plan of Correction is a continuously enhance of care and services p our residents and is su solely as a requiremer provision of Federal an law. This Plan of Corre constitutes a written al substantial compliance Federal Medicare and requirement.	n of mission s or that tty. This desire to the quality rovided to ubmitted at of the and State ection legation of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WTGK11

Facility ID:

000045

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155109	B. WING	,		04/28/2	011
	PROVIDER OR SUPPLIER		STR 811	1 E 12	DDRESS, CITY, STATE, ZIP CODE 2TH ST VAKA, IN46544		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ID I			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFI	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	57 Total						
	Census Payor Ty	pe:					
	5 Medicare	•					
	34 Medicaid						
	18 Other						
	57 Total						
	Sample: 5						
	These deficiencies also reflect State Findings cited in accordance with 410						
	IAC 16.2.	accordance with 410					
	1110 10.2 .						
	Quality review o	ompleted on April 29,					
	2011 by Bev Fau	• •					
	2011 by Bev Fau	iikiici, Kiv					
F0371 SS=F	considered satisfa local authorities; a	, distribute and serve food					
	Based on	observation	F0371		F371-F Sanitary Conditions facility must -(1) Procure food		05/23/2011
	and interv	iew, the			from sources approved or considered satisfactoryby		
	facility fai	iled to ensure			Federal, State or local author and(2) Store, prepare, distrib	ute	
	TOOD Was stored and   conditions. 1) Refrigerat		and serve food under sanitar conditions. 1) Refrigerator #2	2			
	served und	nder sanitary  and the reach-in cooler have received maintenance and temperatures are within normal					
	conditions	s related to			range. Dietary Cook #1 was in-serviced on infection contrrelated to handwashing,		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155109		LDING	00	04/28/2011
		100100	B. WIN		A DDD EGG OWN CHARE THE CODE	04/20/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
GOI DEN	I LIVING CENTER-I	MISHAWAKA		1	WAKA, IN46544	
				ID ID	1	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	refrigerato	or temperatures			appropriate use of gloves, an appropriate use of utensils d	
	being too high and using				food service.2) All residents the potential to be affected b	had
		nds to serve			practice. An audit of current residents was completed to	y uno
					ensure that no residents wer	re
	1000 for 1	of 1 kitchen			affected by this practice.3) T	he
	areas. The	is had the			Dietary Manager/DCE will in-service dietary staff regard	
	potential t	to affect 57			appropriate kitchen sanitatio refrigerator temperatures an	*
	•				food handling/serving accord	~ I
	residents who resided in the facility. (The main				to infection control guidelines maintain sanitary conditions	
					follow guidelines.4) The Diet	ary
	kitchen)				Manager will monitor/audit the kitchen for appropriate sanitation	
	Kitchen				refrigerator temps and food	
					handling/serving according t	
	Findings i	noludo:			infection control and sanitation guidelines. Audits will occur	
	Tillulligs	iiciuuc.			a minimum of five times per	I
					for a minimum of at least 60	days
	1 Damin a	41. a. £.11			or until no further issues are noted. Issues noted by the	
	1. During	; the full			Dietary Manager will be repo	orted
	kitchen sa	nitation tour			to the E.D./designee for revi	ew
	$\int_{100}^{100} \frac{1}{4} \frac{1}{27} \frac{1}{11}$	1 at 3:40 p.m.,			and corrective action as nee The Dietary District Manage	
		•			the E.D./designee will follow	
	with Dieta	ary Cook #2 the			on a weekly basis x 4 weeks then monthly until no further	
	follows	as observed:			issues are noted. Any conce	I
	TOHOWS W	as ouserveu.			will be monitored through Q/	AA
	A. The temperature of the refrigerator on the				process for a minimum of the months. If no issues are note	I
					after completion of the mont	· ·
					QAA process for three month	ns,
					monitoring will be decreased	I to
		ALWOOL OIL WIL			an as needed basis as determined by the QAA	
					1 23.5	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155109	A. BUI B. WIN	LDING IG		04/28/2	
NAME OF F	PROVIDER OR SUPPLIER	<b>!</b>	'		ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	MISHAWAKA		1	2TH ST NAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	ΤE	COMPLETION DATE
	inside the	rmometer			committee. If issues continue to be identified, the QAA committee		
	indicated	a temperature			will continue to monitor the is identified on a monthly basis		
	of 50 degrees				one month has passed with issues being identified, at wh	no	
	Fahrenhei	t. The			time monitoring will be decre to an as needed basis as	ased	
	temperatu	re on the			determined by the QAA committee.		
	thermome	thermometer located on					
	the outside of the cooler indicated a temperature						
	of 52.6 de	grees. This					
	cooler was	s identified as					
	refrigerato	or #2. There					
	was a bow	vl of butter					
	pads and a	a pitcher of a					
	flavored d	Irink inside the					
	refrigerato	or.					
	Interview	with Dietary					
	Cook #2 at the time, indicated the refrigerator works sometimes.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155109		A. BUIL		00	COMPL 04/28/2				
NAME OF PROVIDI			B. WINC	STREET A 811 E 12	ADDRESS, CITY, STATE, ZIP CODE  2TH ST  WAKA, IN46544	1 25/2			
(X4) ID PREFIX (	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
B. the local table term degrated our the regards. Fair C. ob	The tender reaching and the reaching rees Faside the reaching reaching and the reaching reach	in cooler the steam an inside re of 45 ahrenheit. refrigerator ses of milk, f flavored , and pureed salad. The ermometer on in cooler 48 degrees			(EACH CORRECTIVE ACTION SHOULD BE	ATE			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		ONSTRUCTION 00	(X3) DATE S COMPL		
		155109	B. WIN	G		04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  2TH ST		
	I LIVING CENTER-I			MISHA	WAKA, IN46544		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	e cook was					
		pair of gloves					
	to both of	her hands.					
	The cook	was observed					
	stirring the	e vegetables in					
	a large par	n with the					
	gloved hands. She then						
	opened a jar of salad						
	dressing a	nd poured the					
	salad dres	sing into a					
	measuring	g cup with the					
	same glov	red hands. The					
	cook was	observed					
	wiping he	r forehead with					
	the same g	gloved hands.					
	The cook	then stirred the					
	vegetable	salad. After					
	she was fi	nished, she					
	then left th	he kitchen					
	wearing th	ne same pair of					
		•					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155109		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		811 E 1	ADDRESS, CITY, STATE, ZIP CODE 12TH ST WAKA, IN46544	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
	gloves. A	t no time, did				
	she remov	ve the gloves				
	and wash	her hands with				
	soap and v	water after				
	touching l	ner forehead.				
	2. On 4/27/11 at 6:06					
	p.m., Diet	ary Cook #1				
	was obser	ved serving the				
	supper me	eal in the				
	kitchen or	n the tray line.				
	The Dieta	ry Cook was				
	wearing a	pair of gloves				
	to both of	her hands.				
		ry Cook was				
	observed	touching				
	plates, ute	ensils, and lids				
	with her g	loved hands.				
	The Dieta	ry Cook was				
	then obser	rved reaching				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155109			LDING	NSTRUCTION  00	(X3) DATE COMP: 04/28/2	LETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	MISHAWAKA		811 E 1: MISHAV	2TH ST VAKA, IN46544		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	into the ba	ag of potato					
	chips with those same						
	pair of glo	oved hands and					
	grabbed a	handful of					
	chips and	placed them					
	onto the re	esidents's					
	plates. The Dietary						
	Cook also was observed						
	reaching i	nto the bagged					
	"hoagie b	uns" with the					
	same pair	of gloved					
	hands and	placing the					
	buns onto	the resident's					
	plates. Th	ne Dietary					
	Cook did	not use any					
	type of uto	ensil to do this,					
	she used h	ner gloved					
	hands. Th	ne Dietary					
	Cook did	not stop and					
	change he	er gloves during					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155109	A. BUII B. WIN			04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  2TH ST	•	
GOLDEN	I LIVING CENTER-I	MISHAWAKA		1	WAKA, IN46544		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG			DATE
	the above	observations					
	or wash h	er hands with					
	soap and v	water.					
	Interview	with Dietary					
	Cook #1 at the time,						
	indicated she had always						
	served potato chips and						
	buns that	way with her					
	gloved has	nds. She					
	indicated	at the time, that					
		o idea what					
		should be					
	_	rve the potato					
		•					
	_	did she know					
	•	air tongs were					
	to serve th	ne buns.					
	The Dieta	ry Cook					
	continued	to do this four					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155109		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/28/2011	
	PROVIDER OR SUPPLIER		811 E 1	ADDRESS, CITY, STATE, ZIP CODE I 2TH ST WAKA, IN46544	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	more time	s until she was			
	asked to use a scoop for				
	the potato	chips and			
	tongs for t	the buns.			
	This Federal Tag relates to Complaint Number 00089363.				
	3.1-21(i)(2	2)			
F0465 SS=F	sanitary, and commesidents, staff and Based on observation facility failed to kitchen areas cleadirty walls, dirty 1 of 1 kitchen are potential to affect resided in the factorial factorial to affect resided in the factorial factorial to affect resided in the factorial factori	keep the kitchen and an related to dirty floors, vents, and dirty carts for eas. This had the t 57 residents who cility. (The main kitchen)	F0465	F465-F Safe/Functional/Sanitary/Coortable Environment The famust provide a safe, function sanitary, and comfortable environment for residents, stand the public. 1) The kitche floor, walls, equipment, vents pipes and connecting tubes been cleaned and sanitized. residents had the potential to affected by this practice. An of current residents was completed to ensure that no residents were affected by the	cility nal, caff en s, have 2) All b be audit

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155109	B. WIN	IG		04/28/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				1	2TH ST		
GOLDEN	I LIVING CENTER-I	MISHAWAKA		MISHA	WAKA, IN46544		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	following:				practice.3) The Dietary Mana will monitor/audit the kitchen		
					appropriate sanitation accord		
	A. The kitchen floor had a large				to guidelines. Audits will occi	•	
	accumulation of food crumbs on it.				a minimum of five times per		
	Interview with D	ietary Cook #2 at that			for a minimum of at least 60	days	
	time, indicated th	ne floor was to be swept			or until no further issues are		
	three times a day	after each meal, and the			noted. Issues noted by the Dietary Manager will be repo	rted	
	last time it was s	wept was around 10:30			to the E.D./designee for review		
	a.m.	_			and corrective action as nee		
					The Dietary District Manager		
	B. There was a l	arge accumulation of			the E.D./designee will follow		
		food particles under the			on a weekly basis x 4 weeks then monthly until no further	,	
	food prep table.	Took purvious under the			issues are noted.4) Any cond	cerns	
	100 <b>a</b> prop more.				will be monitored through QA		
	C. Both white flo	oor vents located on the			process for a minimum of thr months. If no issues are note		
	air conditioner ha	ad a large amount of dirt			after completion of the month		
		n them. The black foam			QAA process for three month	-	
		the air conditioner pipes			monitoring will be decreased	to	
	· -	ried food spillage and was			an as needed basis as		
	cracked in many				determined by the QAA committee. If issues continue	a to	
					be identified, the QAA comm		
	D The white wa	Il tile located throughout			will continue to monitor the is		
		dirty with dried food			identified on a monthly basis		
	and/or beverage	•			one month has passed with		
	and/or beverage	spinage.			issues being identified, at wh		
	E The fleet	ler the dish machine was			time monitoring will be decre to an as needed basis as	aseu	
					determined by the QAA		
	*	back splash behind the			committee.		
		s observed with dried					
	food and/or beve	rage spillage.					
	F. The wheels on four transportation carts had a heavy accumulation of dirt and						
	grease.						

000045

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A DULL DING  00			(X3) DATE SURVEY COMPLETED		
		155109	A. BUILDING B. WING			04/28/2011		
NAME OF F	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVING CENTER-MISHAWAKA				811 E 12TH ST MISHAWAKA, IN46544				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ID	7100, 114-00		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	G. There was a large amount of food crumbs and dirt noted on the floor behind							
	the griddle, stove, and convection ovens							
	and against the baseboard.							
	H. There was dirt and food crumbs under the steam table.							
	I. There was a large amount of dust and							
	grease on top of the convection ovens as							
	well as on the sides of the convection							
	ovens.							
	J. There was dust and grease observed on							
	the pipes and connecting tubes behind the oven.							
	Interview with Dietary Cook #2 at that time, indicated all of the above was in need of cleaning.							
	This Federal Tag relates to Complaint							
	Number 00089363							
	21.10/0							
	3.1-19(f) 3.1-21(i)(2)							
	3.1-21(1)(2)							